This Information Should Be Directed to the Management Staff of Your Agency

Bureau Talk

Missouri Department of Health
Bureau of Home Care and Rehabilitative Standards

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LICENSURE NOTICE

Criminal Background – Employee Disqualification Checks

Criminal background checks and employee disqualification list (EDL) checks can now be obtained by two methods, both methods acceptable by the Bureau during the survey process. The current process involves section 660.317, RSMo, which directs providers to request a criminal background check and to make an inquiry to the department of social services for an EDL check. The Family Care Safety Registry (FCSR) became effective January 1, 2001, which provides access to background information on registered child-care and elder-care workers. Section 210.933. RSMo states "For any elder-care worker listed in the registry or who has submitted the registration form as required by sections 210.900 to 210.936, an elder-care provider may access the registry in lieu of the requirements established pursuant to section 660.315, RSMo, or to subsections 3, 4 and 5 of section 660.317, RSMo. Therefore, agencies can develop policies relating to which method their agency will follow to obtain the background information for their employees. There are some differences in the type of information you will receive. With the background checks per 660.317, RSMo, you will receive information on both misdemeanor and felony charges; with the FCSR background checks, you will **not** receive information on misdemeanor charges. However, with the FCSR background checks in addition to the criminal background information and the EDL information, you will receive information from child abuse/neglect records maintained by the Division of Family Services; child-care facility licensing records maintained by the Department of Health; foster parent, residential care facility and child placing agency licensing records maintained by the Division of Family Services and residential living facility and nursing home licensing records maintained by the Division of Aging. Remember, for licensing and certification purposes, the Bureau will accept whichever background check method your agency chooses. ◆

OSHA REQUIREMENT

Hepatitis B Vaccination

Employers must "make available the hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and post-exposure evaluation and follow-up to all employees who have had an exposure incident." Such vaccines must be made available at no cost to the employee, made available at a reasonable time and place, performed by or under the supervision of a licensed health care professional and available within 10 working days of initial assignment. For further information, please refer to the OSHA regulations.◆

MEDICARE NOTICES

Home Health

OBQM Reports

The Bureau of Home Care and Rehabilitative Standards, as the state survey agency, has access to the OBQM reports. These reports consist of the case-mix and adverse event outcome reports compiled from the OASIS data. The Bureau will begin immediately to review these reports as part of the pre-survey preparation as directed by HCFA. Keep in mind these reports only contain information about an agency's Medicare and Medicaid patients, were primarily designed for the agencies to use to assist them in improving patient outcomes and for quality monitoring purposes, not as a survey tool. The surveyors, during a survey process, will continue to review the comprehensive assessment, the plan of care, patient's medications, visit notes, clinical notes, physician's orders, patient objectives and outcomes and conduct home visits in order to assess compliance with the Medicare CoPs.

HHAs have had access to the OBQM reports since January 26, 2001. HCFA now expects HHAs to begin incorporating a review and investigation of these reports into the annual evaluation of your program, any patient care review program and to include them as part of your quarterly clinical record reviews. ◆

Social Security Act Amended

The Social Security Act was amended effective December 21, 2000, by adding new sentences in the statutory language of the homebound definition as follows:

"Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration."

This new statutory provision does not imply that Medicare coverage has been expanded to include adult day care services. It does not change the existing homebound guidelines beyond the two specific provisions. ◆

Medicare Home Health Benefit

If a Medicare beneficiary is under a home health plan of care, all therapy services, that is physical therapy, occupational therapy, speech therapy delivered under the home health benefit whether they are furnished directly by the HHA or under arrangement on behalf of the HHA are bundled into the Prospective Payment System home health payment rate. If an eligible beneficiary is under a home health plan of care, then the HHA is responsible for providing the therapy services either directly or under arrangement during an open 60-day episode.

If a Medicare beneficiary under a home health plan of care is receiving therapy services from another provider under arrangement made by the HHA as part of the home health benefit simply because the required equipment cannot be made available at the patient's home, the Medicare conditions of participation apply, including the comprehensive assessment and collection and reporting of OASIS data by the HHA. ◆

Home Health Cont.

P.T.A.'s Serving Home Health Patients

There has been quite a lot of phone calls to our office in the recent months regarding qualifications for a Physical Therapy Assistant. The Federal Conditions of Participation as well as state regulations define a P.T.A. as, *"a person who is licensed as a physical therapy assistant, if applicable by the State in which practicing, AND has graduated from a 2-year college-level program approved by the American Physical Therapy Association."* There is an additional clause in the regulations for P.T.A.'s that passed a proficiency examination prior to December 31, 1977. This regulation only applies to P.T.A.'s practicing in the home health field. There are other regulations P.T.A.'s must follow if practicing in hospitals, nursing homes, etc. ◆

Agencies Seeking Initial Certification

Prior to receiving Medicare approval, HHAs must meet certain requirements, including providing skilled home health services to a minimum of 10 patients. Compliance with the CoPs is determined via an onsite survey and any applicable action or revision required of the HHA following the initial survey. After survey, the new HHA cannot bill Medicare for payment of services to Medicare beneficiaries until the effective date for Medicare participation has been determined by HCFA.

Notification of the effective date may come many weeks after the initial survey. The date of compliance may vary depending on the outcome of the onsite survey. The date of compliance is either the date the onsite survey is completed if, on the date of the survey the HHA meets all CoPs and any other requirements as required by HCFA; or if the HHA fails to meet any of the requirements as a result of the onsite survey, compliance is the earlier of the date the HHA meets all requirements or the date the HHA meets all the CoPs and submits an acceptable plan of correction for standard level deficiencies.

Payment under Medicare for services provided prior to the effective date for Medicare participation is not permitted. As such, it is important that new HHAs seeking payment under Medicare establish the required 60-day episode on or after the effective date of their Medicare participation.

If the HHA is confident that it has met all CoPs at the time of the initial survey is completed, the HHA should do a new start of care assessment, that is, Reason For Assessment #1, on each of its Medicare patients at the first billable visit after the onsite survey. Delay encoding and transmitting the assessment until the Medicare provider number is assigned. The date of this assessment will become day 1 of the HHA's first 60-day episode under Medicare, as long as the assessment was done in conjunction with a billable visit.

For all other patients treated by the HHA (non-Medicare patients) if a new start of care date is not required by the patient's pay source, the HHA should encode and transmit all OASIS assessments as required by current regulation that were collected after the effective date of Medicare participation. ◆

Advance Beneficiary Notice (ABN)

Beginning March 1, 2001, HHAs must use form HCFA-R-296 whenever any of the triggering events occur that require issuance of an ABN. An ABN is required when an HHA determines that Medicare is not likely to pay for otherwise covered home health care that a physician has ordered. The determination is based on one of these exclusions in the Social Security Act: medical necessity, custodial care, homebound and intermittent care.

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Situations in which an HHA advises a beneficiary that it will not accept the beneficiary as a Medicare patient because it expects Medicare will not pay for the services, the HHA must provide an ABN to the beneficiary prior to furnishing home health services. In a situation in which the HHA proposes to reduce a beneficiary's home health services because it expects Medicare will not pay for any services at the current level and/or frequency of care, the HHA must provide an ABN to the beneficiary before it reduces services to the beneficiary. In a situation in which the HHA proposes to stop furnishing all home health services to a beneficiary, because it expects Medicare will not continue to pay for the services, the HHA must provide an ABN to the beneficiary before it terminates such home health services. ◆

Hospice

Social Security Act

The Social Security Act was amended effective December 21, 2000, clarifying that the certification of terminal illness of an individual who elects hospice "shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." Please note that it still applies that an individual is considered to be terminally ill if the medical prognosis is 6 months or less.

The amendment to the Act clarifies current policy that the certification is based on clinical judgment regarding the normal course of illness and further emphasizes understanding that making medical prognostication of life expectancy is not always exact. ◆

Use of Short-Term General Inpatient Level of Care

Hospice patients may be admitted for short-term general inpatient care when the patient needs pain control or acute or chronic symptom management that cannot be feasibly provided in other settings. In addition, the need for short-term general inpatient care may be precipitated by an acute breakdown in the caregiver support system in the home requiring an inpatient intervention to safely care for the patient's needs. It is not appropriate for hospices to encourage a patient to revoke to avoid hospice responsibility for a short-term general inpatient level of care that is needed for the terminal illness. ◆

Hospice Regulations

State hospice regulations were published in the Missouri Register February 15, 2001, with the comment period ending March 17th. There were several comments, which will be answered in print, and the regulations will be republished in final form. ◆

OPT's

Services Provided

An OPT/OSP provider may provide services "on its own premises, on the premises of another provider of services, e.g., hospital or SNF, or in the individual's place of residence." However, if such a provider is providing their services in an "individual's place of residence" – by state law found at 197.400 RSMo, such providers must be licensed as a home health agency. Please contact our office for guidance if your OPT/OSP is providing services in patient's residences. Remember, a patient's residence can be private homes, residential care facilities, assisted living facilities and skilled nursing facilities. ◆

Informational Bulletins (Bureau Talk) Available on website beginning April 2nd